LEGISLATORS: STATE OF CONNECTICUT APPROPRIATIONS COMMITTEE

Members of the Appropriations Committee I appreciate the opportunity to provide testimony regarding the Health & Hospitals Budget, particularly that portion devoted to the Department of Mental health & Addiction Services [DMHAS]. My name is Ronald Fleming [Ph.D., LCSW]. I am the President and CEO of Alcohol and Drug Recovery Centers, Inc. [ADRC, Inc.], in Hartford, Connecticut. Today I am here also speaking as a member of the Connecticut Association of Substance Abuse Agencies (CASAA) and on behalf of ADRC, Inc.

ADRC, Inc. serves approximately 3,000 different persons each year in over 5,000 episodes of care provided through the operation of 150 residential beds and two outpatient counseling centers. We employ a diverse workforce of 135 fulltime persons and an additional 65 part-time persons in one of the poorest communities in the state.

My Agency operates services from six [6] different buildings located in the greater Hartford area. Providing services to drug and alcohol addicted persons requires safe, secure, and supportive settings which can meet the requirements of health departments, fire departments, accrediting bodies, and funding agencies [such as DMHAS].

A variety of grants from the Department of Mental Health & Addiction Services [DMHAS] provide approximately 45% of the funding required to operate the twenty different programs we operate. A substantial percentage of our remaining operating funds come from fee for service revenue related to providing care to indigent persons who are covered by the Behavioral Health portion of the SAGA medical benefit – also overseen by DMHAS. Many of the agencies throughout the state that provide substance abuse services to SAGA recipients are configured and funded in a very similar manner.

I am here to advocate for maintaining DMHAS's ability to operate the existing network of client services that are provided by private not for profit agencies. These agencies provide care to thousands of Connecticut residents – effectively and at low taxpayer cost. At the same time I

am here to point out the vulnerabilities of the private non-profit agencies – should the DMHAS grant, fee for service, or administrative support budgets be subject to reductions.

Vulnerabilities:

Human Resource Costs

Salary & Benefits: My colleagues and I have come to the legislature year after year trying to impress upon you the tremendous disparity that exists between private non-profit provider salary rates and that of their peers working for State agencies. The COLA provided two years ago was welcome support but did not address the fundamental disparities that continue to exist. In addition, due to the inconsistent availability of COLA support or rate relief most agencies have not been able to keep up with the escalation in their payroll costs. At my Agency our most recent health insurance cost increases were the equivalent of 62% of last years COLA [the total cost of our current health insurance now exceeds one million dollars]. Anticipating two more years without COLA or rate relief will pose a substantial hardship on vulnerable agencies.

Physical Plant

Physical plant – Maintenance & Repair: A related and comparably serious problem for most agencies is the cost of maintaining and repairing the infrastructure of their service structure. Buildings, computer systems, and vehicles constitute critical aspects of most agencies and yet are not adequately supported by existing funding arrangements with the State of Connecticut. Grants typically do not allow agencies to make "capital expenditures" [costs of $5,000 or more]. Even in cases where agencies attempt – through budget controls – to save $5,000 to $10,000 for a major infrastructure expense these expenditures are typically not allowed under existing funding rules. Two more years without rate relief will exacerbate the burdens of maintaining physical plants.

Service Demand

Sustained – Possible Increased – Demands for Services – For most agencies, including my own, demand for care is constant and unrelenting. Most agencies anticipate that due to the difficult economic times the demand for indigent care substance abuse services will likely

increase. Agencies, due to their funding structure and tenuous supports are not able to accommodate any loss of funding or reduction of support. We are concerned about the impact any efforts to reduce General Assistance Managed Care funds will have on the ability of providers to provide services to clients.

Lack of Rate Relief

Rate relief is fundamentally critical to our sustaining the ability to care for our neediest citizens and to provide a living wage to the persons who provide their care – our staff. For example, our Detoxification Center has received 19.2% in rate increases **since 1997** – an annual rate of approximately 1.6%. Inflation alone rose nearly 33% in the same time period [a 14% disparity]. Many rates do not reflect the actual cost of providing the service. For example, rates for outpatient visits with a doctor [to evaluate and monitor medication] run $5 to $40 less than the actual cost of paying the doctor to provide the care [other related costs not included] – yet these services are critical to many clients.

- One final point, in the last several years Agencies such as ADRC, Inc. and others in CASAA have also struggled with spiraling costs of health insurance, utility bills, and trying to maintaining an aging infrastructure of facilities. Infrastructure issues are particularly difficult in that these expenses, while critical to program operation, can rarely, if ever, be directly supported by grant funds [61% of our grant funds can not be used for capital expenditures]. Connecticut citizens are well served by the efforts of hundreds of non-profit agencies, such as ADRC, Inc. and those in CASAA. I believe that the Legislature and your constituents would find every dollar invested in the non-profit agencies that serve Connecticut would be a dollar well spent.

See attached Tables:

1. Reimbursement Rate Changes 2003-2008
2. Medication Management Costs & Reimbursement Rates.

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****END OF TESTIMONY****

1. Reimbursement Rate Changes 2003-2008

	Reimbursement Rate		Total Rate Change %	Total Inflation %	Annual Rate Change %
	2003	2008			
Intensive Outpatient Service [group care]	$83.00	$89.76	8.1%	16.17	**1.35%**
Medication Management[1] [up to 20 minutes]	$25.93	$29.38	13.3%	16.17	**2.5%**
Medication Management[1] [up to 45 minutes]	$50.62	$57.35	13.3	16.17	**2.5**
Detoxification Rate [daily rate]	$248.00	$268.21	8.1%	16.17	**1.6%**
Outpatient Group Treatment [90 minute session]	$16.87	$19.12	13.3%	16.17	**2.5%**
Clayton [daily rate]	$65.00	$80.34	23.6%	16.17	**4.3%**
Intensive [daily rate]	$150.00	$152.48	1.65%	16.17	**.35%**
Intermediate [daily rate]	$105.00	$108.15	3.0%	16.17	**.6%**
Coventry [daily rate]	$85.00	$80.34	-5.4%	16.17	**-1.0%**

[1]See Medication Management Information in Table 2 – below.

2. Medication Management Costs & Reimbursement Rates.

Medication Management Service	Reimbursement Rate		Actual Physician Cost – 2008[2]	Financial Loss per visit[2]
	2003	2008		
Medication Evaluation [up to 45 minutes	$50.62	$57.35	$97.00	$39.65
Medication Evaluation [up to 20 minutes]	$34.09	$38.63	$43.00	$4.64
Medication Management [up to 20 minutes]	$25.93	$29.38	$43.00	$4.64

[2]Physcain cost and loss per visit do not include any related costs.